

Registration District No. 496

Primary Registration District No. 3025

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 years years, months or days

3. (a) PRINT FULL NAME ALBERT GIDEON SHAUL

3. (b) If veteran, name war None 3. (c) Social Security No. 493-18-6512

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Pearl Shaul 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased March 23 1870 (Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 29 If less than one day hr. min.

9. Birthplace Adams County Illinois (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Gideon W. Shaul

13. Birthplace (Unknown) Indiana (City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Bryant

15. Birthplace Adams County Illinois (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Pearl Shaul

(b) Address Brookfield

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24 '40 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Hill Funeral Chapel

(b) Address Brookfield Mo.

19. (a) 12-24-40 (Date received local registrar) (b) Goodman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town Brookfield (If outside city or town limits, write "RURAL")
(d) Street No. 713 Mc Gowan (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1940 hour 2:35 minute PM

21. I hereby certify that I attended the deceased from Aug 18, 1939, to Dec 18, 1940
that I last saw him alive on Dec 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to Hypertension

Due to _____

Other conditions 14 W (Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. H. Patten (M. D. or other) MD

Address Brookfield Mo Date signed 12-23-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

J. M. Blacklock

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. Ch. Blacklock

Licensed Embalmer No. *2246*

P. O. Address. *Brookfield Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.